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Case Study

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HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda

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ABSTRACT: HealthPartners is the nation's largest nonprofit, consumer-governed health care organization, providing health and dental care and coverage to more than 1 million individuals in Minnesota and surrounding states. Key factors driving HealthPartners' performance are a consumer-focused mission; a regional focus, scale, and scope integrating a broad range of services; strategic use of electronic health records to support care redesign; and a culture of continuous improvement. A comprehensive model for improvement includes setting ambitious targets for health system transformation; measuring what is important in order to optimize care; agreeing on best care practices and supporting improvement at the clinic level; aligning incentives with goals; and making results transparent internally and externally. HealthPartners' experience suggests that a nonprofit health plan market oriented to physician group practice—supported by collaborative measurement, improvement, and reporting structures—creates a community environment that helps each participant achieve objectives more effectively.

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OVERVIEW

In August 2008, the Commonwealth Fund Commission on a High Performance Health System released a report, *Organizing the U.S. Health Care Delivery System for High Performance*, that examined problems engendered by fragmentation in the health care system and offered policy recommendations to stimulate greater organization for high performance.[1] In formulating its recommendations, the commission identified six attributes of an ideal health care delivery system (Exhibit 1).

HealthPartners is one of 15 case-study sites that the commission examined to illustrate these six attributes in diverse organizational settings. Exhibit 2 summarizes findings for HealthPartners, focusing primarily on the ambulatory care

Exhibit 1. Six Attributes of an Ideal Health Care Delivery System

- ***Information Continuity*** Patients' clinically relevant information is available to all providers at the point of care and to patients through electronic health record systems.
- ***Care Coordination and Transitions*** Patient care is coordinated among multiple providers, and transitions across care settings are actively managed.
- ***System Accountability*** There is clear accountability for the total care of patients. (We have grouped this attribute with care coordination since one supports the other.)
- ***Peer Review and Teamwork for High-Value Care*** Providers (including nurses and other members of care teams) both within and across settings have accountability to each other, review each other's work, and collaborate to reliably deliver high-quality, high-value care.
- ***Continuous Innovation*** The system is continuously innovating and learning in order to improve the quality, value, and patients' experiences of health care delivery.
- ***Easy Access to Appropriate Care*** Patients have easy access to appropriate care and information at all hours, there are multiple points of entry to the system, and providers are culturally competent and responsive to patients' needs.

setting. Information was gathered from HealthPartners' system leaders and from a review of supporting documents.[2] The case-study sites exhibited the six attributes in different ways and to varying degrees. All offered ideas and lessons that may be helpful to other organizations seeking to improve their capabilities for achieving higher levels of performance.[3]

ORGANIZATIONAL BACKGROUND

HealthPartners, headquartered in Minnesota's Twin Cities, is the nation's largest nonprofit, consumer-governed healthcare organization. Its mission is to "improve the health of our members, our patients, and the community." The organization was formed through a 1992–1993 merger between Group Health, one of the nation's oldest staff-model health maintenance organizations (HMOs) founded in 1957; MedCenters Health Plan, a network-model HMO; and Regions Hospital (formerly St. Paul-Ramsey Medical Center), a 427-bed teaching hospital and level I trauma center. Two 25-bed critical-access hospitals have since joined the system: Westfields Hospital in New Richmond, Wisconsin, and Hudson Hospital and Clinics in Hudson, Wisconsin.

Today, HealthPartners provides individual, group, and public insurance coverage to more than 1 million members of health and dental plans in Minnesota, western Wisconsin, North and South Dakota, and Iowa (Exhibit 3). Members receive care from a network of some 30,000 providers including both owned and contracted medical groups, specialty clinics, hospitals, and dental practices. Other lines of business include behavioral health, eye care, disease management, integrated home care and hospice, pharmacy, wellness, and personalized health promotion for individuals and groups. The organization employs almost 10,000 and has annual revenue of $3.1 billion.

About one-third of HealthPartners' 640,000 health plan members receive care from the HealthPartners Medical Group (HPMG), a multispecialty group practice that employs more than 600 physicians who practice at 50 HealthPartners clinic locations throughout the Twin Cities and in St. Cloud and Duluth, Minn. (Exhibit 4). HPMG also provides care for patients who have other insurance (including Medicare or Medicaid), who represent about 40 percent of the medical group's 400,000 patients. Each

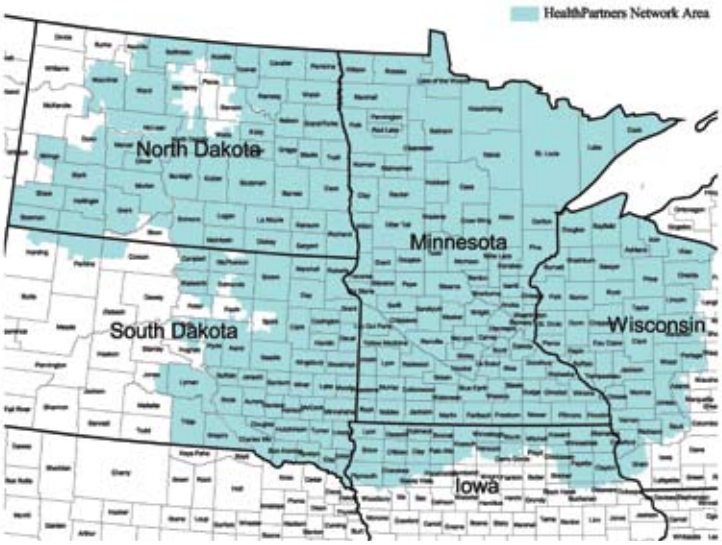
Exhibit 2. Case Study Highlights

Overview: HealthPartners is a family of nonprofit, consumer-governed, integrated health care organizations including a teaching hospital and two critical-access hospitals; the multispecialty HealthPartners Medical Group (HPMG), with more than 600 physicians practicing in 50 clinics; health and dental plans offering group, individual, and public insurance coverage to more than 1 million individuals through a network of 30,000 providers in Minnesota, western Wisconsin, North and South Dakota, and Iowa; a research foundation; and a medical-education institute.

Attribute	Examples from HealthPartners
Information Continuity	Enhanced electronic health record (EHR) system. Patient information is integrated across HPMG clinics with disease registries, clinical reminders, safety alerts, and evidence-based decision support to guide care processes before, during, and after the patient visit. Online personal health record and health assessment. HPMG patients also can schedule appointments, refill prescriptions, share secure e-mail with clinicians, receive preventive care reminders, and view lab results, medications, and immunizations online. Participation in Minnesota Health Information Exchange. Secure interchange of clinical information will facilitate patients' movement among medical groups and health systems.
Care Coordination and Transitions; System Accountability*	EHR supports care transitions for HPMG heart-failure patients after hospital discharge. Chronic disease management programs identify eligible health plan members, engage them in self-care, and promote medication compliance, appropriate treatment, home monitoring, communication, and follow-up in coordination with primary care physician. For example: Behavioral health management includes early intervention program to identify and refer members at risk of depression or problem drinking, medication management programs to promote treatment adherence, and case management to coordinate services for members at risk of behavioral health crises. Workplace wellness programs foster population health improvement by assessing employees for health risks, offering telephonic coaching and education to support lifestyle changes, and promoting engagement through incentives.
Peer Review and Teamwork for High-Value Care	Prepared Practice Teams in HPMG primary care clinics use a "Care Model Process" and EHR to standardize care processes, anticipate patient needs, give evidence-based care, and ensure follow-up after visits.
Continuous Innovation	Comprehensive improvement model disseminated through leadership teams, workforce development, and participation in collaborations such as the Institute for Clinical Systems Improvement help develop common clinical guidelines and improvement strategies. Elements include: (1) set ambitious targets for health system transformation, (2) measure what is important in order to optimize care, (3) agree on best care practices and support improvement at the clinic level, (4) align incentives with goals, and (5) make results transparent. Performance feedback and incentives and tiered networks encourage contracted providers to improve value.
Easy Access to Appropriate Care	Health plan offers "nurse navigators," after-hours nurse-advice call line, and open-access options with no referral required to see a specialist. Advanced-access scheduling is associated with reduced appointment waiting time and increased continuity of care with the same provider in HPMG primary care clinics. Walk-in urgent care and retail convenience clinics seek to integrate with traditional clinics. Well@Work work-site clinics offer acute care and health promotion. Cultural competency initiatives include professional translators, translated materials, educational resources, and the collection of demographics at point of care.

*System accountability is grouped with care coordination and transitions, since these attributes are closely related.

Exhibit 3. HealthPartners Network Area



Source: HealthPartners.

clinic, and the medical group as a whole, is led by a physician-administrator pair.

The HealthPartners Research Foundation conducts clinical, health-services, and basic science research in the public domain, with a focus on improving health care and health through partnerships with care delivery organizations. The HealthPartners Institute for Medical Education sponsors 16 medical residency programs and 240 continuing medical education programs. The institute jointly sponsors the HealthPartners Simulation Center for Patient Safety at Metropolitan State University, which provides "realistic hands-on experiential learning opportunities" for health care professionals and medical and nursing students from Minnesota and neighboring states.

Minnesota, and the Twin Cities in particular, has been a leader in developing innovative approaches to health care financing and delivery, with a continuing orientation toward physician group practice. Public and private employers are collectively active in value-based

Exhibit 4. HealthPartners Medical Group Clinic Locations

Source: HealthPartners.

purchasing initiatives that develop shared strategies to promote quality and cost-containment goals.[4] Several collaborative organizations bring stakeholders together to develop common clinical guidelines, improvement strategies, measurement metrics, and performance reporting and incentive programs (see Appendix A). By law, HMOs are nonprofit organizations in Minnesota. Three large health plans—HealthPartners, Medica, and Blue Cross Blue Shield—dominate the market.[5]

INFORMATION CONTINUITY

All HealthPartners Medical Group clinicians have access to electronic health records (EHRs) for their patients. The EHR was implemented in stages beginning with pilot sites in the 1990s. In 2001, the medical group implemented online medication ordering and simple documentation using a basic Web-based EHR. By 2003, the group determined that it needed a more robust EHR providing four key capabilities: chart review, physician-order entry (including medications, laboratory tests, and images), documentation, and best-practice alerts and reminders. HealthPartners selected and enhanced a third-party software system (EpicCare from Epic Systems Corp.) to meet these requirements. Installation was completed in primary care clinics by 2005, Regions Hospital by 2006, and specialty and behavioral health clinics by 2008.

HealthPartners has customized the EHR to include advanced capabilities such as disease registries, clinical reminders, safety alerts, and decision support for evidence-based guidelines. Panels of medical experts developed clinical content in core topic areas that was embedded in the EHR to support the delivery of preventive and chronic care services before, during, and after the patient visit. In contrast to stand-alone disease registries, the EHR integrates patient information across health conditions so that clinicians can have a unified view of a patient's history.[6]

The health plan supplies chronic disease registry data to its contracted medical groups so that physicians can track and identify their patients who are in need of evidence-based chronic care services. Medical groups that have an EHR can import the data into their own system to add information that is not available in ambulatory care records, such as hospital admissions and ER visits.

All health plan members can create an online personal health record (PHR) to keep a medical history, track health goals, take an online health assessment, and view their medical claims. Patients of the HealthPartners Medical Group can access additional online capabilities to schedule doctor appointments, request prescription refills, send secure e-mail communications to their care team ("e-visits"), receive e-mail reminders for preventive or chronic care, and view their laboratory test results, medication lists, and immunization records. In adopting this technology, HealthPartners aimed to promote a more collaborative relationship between patients and caregivers while also giving patients greater control of information to better manage their own health.[7]

HealthPartners is participating in a public–private partnership called the Minnesota Health Information Exchange to enable the secure exchange of clinical information such as medical histories, laboratory orders, and test results between providers and payers as patients move among medical groups and health systems.

CARE COORDINATION AND TRANSITIONS: TOWARD GREATER ACCOUNTABILITY FOR TOTAL CARE OF THE PATIENT

Improving care transitions. The HealthPartners Medical Group and Regions Hospital are working together to improve care transitions for patients with heart failure, according to Beth Averbeck, M.D., associate medical director for primary care. For example, primary care physicians receive an electronic alert when one of their heart failure patients is admitted to Regions hospital. When the patient is discharged, the hospital's care managers notify the medical group's heart failure clinic and telephone the patient at home to ensure that he or she has a follow-up appointment and is taking the proper medications. The patient's primary care physician and a cardiac specialist in the heart failure clinic then comanage the patient with a jointly

agreed-upon follow-up schedule, using the EHR to facilitate communication and patient reminders.

To promote improved care transitions across its network, the health plan recently began reporting on hospital readmissions for heart failure patients in each of its cardiology care groups. As part of its performance incentive program for contracted providers (described below), the plan has set a goal of reducing readmissions within 30 and 90 days of an initial hospitalization to 5 percent and 15 percent of these patients, respectively, from current planwide rates of 7.9 percent and 17.3 percent during 2005–2007.[8]

Managing chronic disease. HealthPartners has engaged in a series of innovative and collaborative disease management activities since the early 1990s, focused initially on diabetes. The authors of a previous Commonwealth Fund report noted that the integrated nature of HealthPartners Medical Group (formerly the staff-model HMO) likely reduced the costs and increased the success of developing disease management programs in comparison to efforts by looser networks of independent physicians. They estimated that the economic value of improved quality of life (from reduced disease complications) would be $31,000 for a diabetic patient who participated in the program for 10 years.[9]

The health plan now offers a suite of disease management programs under the name CareSpan that can be purchased by employer groups for their health plan members with conditions such as asthma, diabetes, heart disease, heart failure, and chronic obstructive pulmonary disease. CareSpan uses disease registries, health assessments (described below), and referrals from physicians to identify patients who would benefit from early intervention, disease management, and case management programs. Participants receive personalized education and support from nurses or other professionals such as dieticians for self-care, medication compliance, home monitoring, and follow-up as needed in coordination with their physician and clinic. The plan reported the following audited results for participants in these programs from 2003–2004 to 2005–2006:

- 6 percent reduction in all-cause admissions for members with asthma
- 5 percent reduction in all-cause admissions for members with diabetes
- 13 percent reduction in admissions for heart attack, heart bypass surgery (CABG), and chest pain (angina) for members with coronary artery disease
- 6 percent reduction in all-cause admissions for members with chronic heart failure.

Improving behavioral health. Behavioral health management programs illustrate how HealthPartners is seeking to develop a proactive approach to care management that supports the relationship between patients and their physicians (or other providers) but does not rely exclusively on a patient visit to identify and address health problems. These programs are part of the organization's broader strategy to promote health by removing barriers so that health plan members can more easily access mental health or chemical health evaluation and treatment services when needed, according to Karen Lloyd, senior director of behavioral health strategy and operations. For example, a behavioral health direct-access network allows members to see any outpatient behavioral health professional without prior approval or authorization.

In an early intervention program, licensed behavioral health professionals (social workers or psychologists) contact health plan members whose health assessment indicates a risk for depression or problem drinking—two modifiable risk factors that can affect a person's productivity and ability to manage a chronic disease. During the outreach call, the behavior health professional conducts additional screening to ascertain the nature of the individual's concerns or symptoms. If the individual appears to have an undiagnosed, clinically treatable condition, the professional provides education and guidance to motivate him or her to see a behavioral health professional for a full evaluation. Those with subclinical conditions are offered guidance and provided educational resources on how to reduce their risk for developing depression or alcohol dependency.

A behavioral health disease management program focuses on health plan members with depression who are beginning antidepressant medication. The program sends these members monthly educational material and reminders to refill their prescriptions for six months. The member's physician receives a letter if the patient fails to refill his or her medication in a timely manner. Anecdotal feedback suggests that physicians find this service useful for prompting follow-up with patients. The health plan credits this program with a 17 percent improvement in rates of six-month medication adherence.[10] The plan has expanded the program to promote medication adherence and improved self-care among members with bipolar disorder or schizophrenia, two conditions that put an individual at high risk for poor health outcomes. In addition to sending refill reminders, the program offers brief telephone counseling and referral for those who are not adhering to treatment. This program puts a special emphasis on maintaining physical health, as research indicates that patients with severe mental illness and taking atypical antipsychotic medications lose an average of 25 years of lifespan.

Several years ago the health plan implemented a telephonic case management program after discovering that 5 percent of its members with behavioral health–related diagnoses accounted for 50 percent of expenditures. The program uses a predictive algorithm to identify members who are at risk of behavioral health crises and hospitalizations. A behavioral health case manager invites these members to participate (by letter and then by phone) and provides participants with self-care education, health coaching, decision support, and care coordination services. Case managers can access the EHRs of patients seeing physicians in the HealthPartners Medical Group to facilitate care planning and communication with the care team. In 2007, the engagement rate was about 38 percent and participant satisfaction was 94 percent. Similar case management services are offered to all health plan members with illnesses that put them at risk for poor outcomes and high costs.

The plan's analysis of program effectiveness comparing the study group (whether engaged in the program or not) to a historical comparison group (with costs trended forward) found that ambulatory behavioral health visits were 35 percent higher among the study group, medication costs per member per month were 11 percent lower, inpatient behavioral health days per 1,000 members were 4 percent lower, and costs per member per month were 18 percent lower in the latest annual measurement period.[11] The overall return on investment was estimated at $4 saved in medical costs for every $1 spent on program administration. Recently, the plan has found that residential chemical health days have increased as inpatient mental health days have decreased. Anecdotal information suggests that many members at highest risk for hospitalization have an undiagnosed or untreated chemical health condition coexisting with a mental health condition.

Promoting healthy lifestyles. The health plan encourages each adult member to complete an online health assessment (integrated with his or her personal health record) designed to identify those at risk of developing chronic illnesses, such as diabetes or heart disease, who would benefit from prevention.[12] Participants receive immediate online feedback via a personal report featuring a modifiable risk score (including the change in score since a previous assessment) and an action plan for making lifestyle changes. Results are used to invite the member to participate in disease management programs for which they may be eligible. While health plan–initiated communications strategies help to raise members' awareness of this service, they have not resulted in high participation rates, nor are physicians always prepared to use such information in clinical practice.

HealthPartners has found that the most effective strategy for engaging individuals in healthy lifestyles is to implement the online health assessment together with employer-sponsored programs for improving population health. The health assessment "is a powerful tool to create 'teachable moments' for people that can help mobilize them [into] taking active steps to

health improvement," said Nico Pronk, Ph.D., vice president and health science officer at HeathPartners' JourneyWell program for employers. Realizing this potential requires an integrated approach to connecting employees with programs, he said.

To meet this need, HealthPartners works with employers locally and nationally to develop workplace health programs that offer incentives (such as reduced copayments and deductibles) for employees to engage in annual health assessments and follow-up programs. These programs include curriculum-based telephonic counseling and educational courses to support individuals in making lifestyle changes such as smoking cessation or weight loss, online programs to promote increased physical activity levels, and referral to disease management programs and to workplace-specific resources such as employee assistance programs.

One large Twin Cities employer, BAE Systems, experienced the following results after participating in such a program for three years:

- high levels of reported employee satisfaction with the program
- sustained participation rates of 89 percent or higher annually among the company's 1,300 employees and their spouses
- 6 percent improvement in employees' modifiable risk scores and health behaviors
- 3.3 percent annual reduction in medical claims costs (about half of which was attributed to lower-than-expected hospital admissions), equal to about $59 per employee per year and yielding a 2:1-to-3:1 return on investment
- improved workforce productivity valued at more than $1 million.[13]

PEER REVIEW AND TEAMWORK FOR HIGH-VALUE CARE

Physicians in the HealthPartners Medical Group engage in a formal peer review process at the departmental level. Cases are referred for review based on patient or staff concerns, with a focus on identifying learning opportunities and systems issues to be addressed for improvement. Physicians are invited to join quality improvement teams and to receive training in improvement methods based on their clinical interests. The goal is to develop informal leaders who will spread knowledge and mentor their peers, said Averbeck.

Primary care clinics within the HealthPartners Medical Group have adopted a "Care Model Process" (adapted from Wagner's Chronic Care Model[14]) that defines "a standard set of workflows for delivering evidence-based care that provides a consistent clinical experience for patients and a consistent process for care teams."[15] Each clinic's staff is organized into "prepared practice teams" composed of a physician, a rooming nurse, a receptionist, and others such as a pharmacist or dietician when needed for particular patients. The goal is to create a "continuous healing relationship" between caregivers and patients by making the best use of collective team skills, enhancing communication, and ensuring that care is well-coordinated and responsive to patient needs. These teams typically huddle each morning to review their schedule and objectives for the day.

Through standardization of processes and clearer specification of roles, the care team focuses on reliably performing core patient interactions within a defined patient visit cycle—scheduling, pre-visit, check-in, visit, and post-visit—to anticipate patient needs, remind patients of health issues, and provide follow-up after the visit. For example, pre-visit planning may include identifying preventive care services that will need to be provided at the visit and contacting the patient to schedule laboratory tests so that results are available for review during the visit. At the patient visit, the team uses the EHR to address the patient's health maintenance and/or chronic care needs, refill prescriptions if needed, and schedule future appointments. Patients receive an "after-visit summary" of their care plan to promote treatment adherence and receive outstanding lab results by their preferred method of notification (letter, phone, or e-mail).

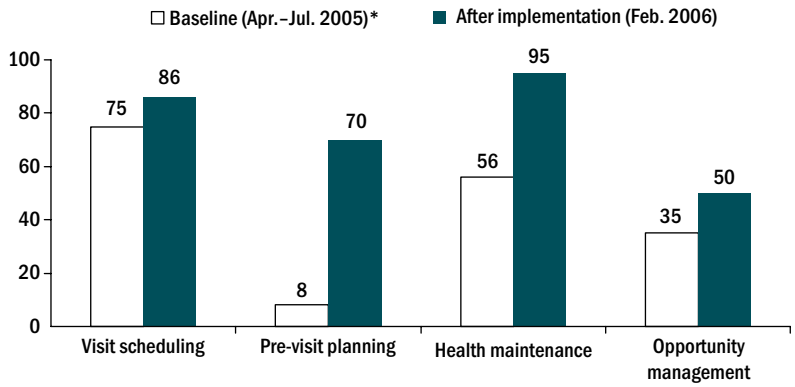
Implementation of the Care Model Process, along with other interventions, was associated with improvements in the quality of care received by

primary care patients, while also laying a foundation for making future improvements in care.[16]

- Pre-visit planning activities increased from 8 percent of patients in 2005 to 70 percent in 2006 (with improvement continuing to more than 90 percent of patients today), and accuracy of health maintenance records rose from 56 percent to 95 percent and has remained near that level since that time (Exhibit 5).
- Patients receiving optimal diabetes care—measured as a composite, or "bundle," of five treatment goals including control of blood glucose, blood pressure, and cholesterol levels; aspirin use; and non-use of tobacco—increased from 4 percent of diabetic patients in 2004 to 15 percent in 2006 and 25 percent in the fourth quarter of 2008 (Exhibit 6). This increase builds on more than a decade of work to improve the quality of diabetes care.[17] Recent improvements were facilitated by the use of a monthly "exceptions report" that identifies diabetic patients who are not up-to-date on planned-care visits, have missed follow-up care, or are not achieving treatment goals. These patients are contacted by telephone or electronic reminder and invited to schedule a visit or other needed services.
- Incorporating the PHQ-9 patient health questionnaire, an assessment tool for depression, into the primary care visit cycle (completed by the patient and documented in the EHR by the rooming nurse) resulted in a doubling of patients who use it, from 32 percent of primary care clinic patients with newly diagnosed depression in 2004 to 65 percent in 2007. The tool provides a structured way for physicians to communicate with patients about their symptoms and to make treatment adjustments as needed.[18]
- Patient satisfaction (percentage reporting a problem) has improved 24 percent since 2006 as the intervention has shifted focus to improving the patient experience. Areas of attention included improving communication with patients about expected waiting time, training staff to consistently demonstrate respect, and making sure that the patient's main reason for the visit has been addressed.

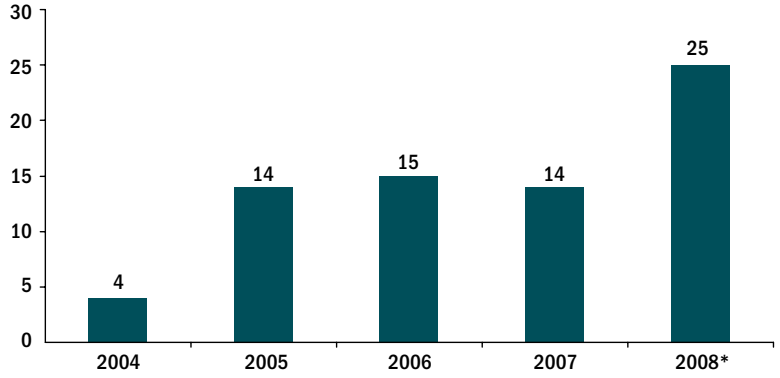
The medical group developed the Care Model Process starting in 2002 through its participation in the *Pursuing Perfection* initiative, funded by the Robert Wood Johnson Foundation and led by the Institute for

Exhibit 5. HealthPartners Medical Group Care Model Process: Summary of Implementation Results



Note: Visit scheduling = percent of primary care visits scheduled where patient was offered needed health maintenance screening; Pre-visit planning = percent of primary care visits that pre-visit planned; Health maintenance = percent of primary care patients where the electronic medical record accurately reflects the patient's needs; Opportunity management = percent of patients will all health maintenance services discussed, offered, ordered, scheduled, and/or provided at the primary care visit.
Source: M. McGrail and B. Waterman, "HealthPartners Medical Group: Care Model Process," *Group Practice Journal*, Nov.–Dec. 2006 55(10):9–20.

Exhibit 6. HealthPartners Medical Group: Achieving Optimal Diabetes Care



*Optimal diabetes care means the percentage of patients aged 18 to 75 with diabetes (Type 1 or 2) who had hemoglobin A1c <7%, LDL cholesterol <100 mg/dl, blood pressure <130/80 mmHg; daily aspirin use (patients ages 41–75), and documented tobacco-free.
**Preliminary fourth quarter data provided by HealthPartners.
Source: Minnesota Community Measurement (www.mnhealthcare.org) and HealthPartners (2008 data).

Healthcare Improvement. Frontline staff from three pilot sites mapped workflows to optimize the patient visit process during a two-day rapid-design process. The model was refined and disseminated to all primary care sites through an internal learning collaborative. Researchers who studied the change at an early stage reported that care teams found it challenging to translate general principles from Wagner's Chronic Care Model into clinical practice, leading to some trial and error as they sought to define a workable approach.[19] Ongoing redesign is based on information gathered from audits and measures of effectiveness, with a current focus on improving outreach between visits (as described above for diabetes).

CONTINUOUS INNOVATION

HealthPartners has developed a comprehensive model for improvement that is disseminated through leadership councils that oversee improvement work, through workforce skills development, and through participation in learning collaborations. The interrelated components of this model include (1) setting ambitious targets for health system transformation, (2) measuring what is important (rather than what is simply easy) for optimizing patient care, (3) agreeing on best care practices and supporting improvement at the clinic level, (4) aligning incentives with goals, and (5) making results transparent internally and externally. Each of these components is described below.[20]

Setting ambitious targets. The organization sets its priorities through a strategic plan and a balanced scorecard with four components: people (the organization's workforce), health outcomes, consumer and patient experience, and financial stewardship (Exhibit 7). The health component includes *Health Goals 2010* (see Appendix B), the organization's blueprint for achieving the Institute of Medicine's (IOM's) six criteria for a successfully transformed health care system: care that is patient-centered, safe, timely, effective, efficient, and equitable.

Setting ambitious goals implies that the organization is committed to creating "the capacity to try and make them a reality," said Mary Brainerd, HealthPartners' CEO. This means "not just setting a goal and hoping for the best, but a strong commitment of resources to make it happen." To ensure that these aspirations will be translated into action, the board of directors established the Health Transformation Committee, which sets goals and oversees the organization's efforts to redesign systems in pursuit of the IOM aims.

One of the plan's health goals, for example, is to achieve 100 percent improvement in a composite of lifestyle measures for adults including tobacco and alcohol use, physical activity, healthy weight, and

nutrition. To reach tobacco use prevention goals, the health plan offers incentives and supports collaborative efforts to help medical groups adopt tobacco control interventions recommended by the Centers for Disease Control and Prevention: *asking* patients about tobacco use (by making tobacco use a "vital sign" in the medical record), *advising* tobacco users to quit, and *assisting* them with a plan to quit (such as by prescribing medication and referring them to telephone counseling). The plan has seen the following improvements among its member population (Exhibit 8).[21]

- Patients who were assessed by their clinicians for tobacco use increased from 71 percent of health plan members in 1998 to 96 percent in 2007. Almost two-thirds (65%) of tobacco users reported that they were offered assistance in quitting in 2008, as compared to fewer than half (47%) who said so in a 2001 health plan survey.

- Self-reported tobacco use declined by almost half among adult health plan members, from 25 percent in 1998 to 13 percent in 2006—a rate that was sustained through 2008. This was twice the improvement seen in tobacco use statewide, which fell from 27 percent to 21 percent of Minnesota adults from 1999 to 2007.[22]

- Parent-reported secondhand smoke exposure among children of health plan members declined from 23 percent in 1998 to 5 percent in 2008.

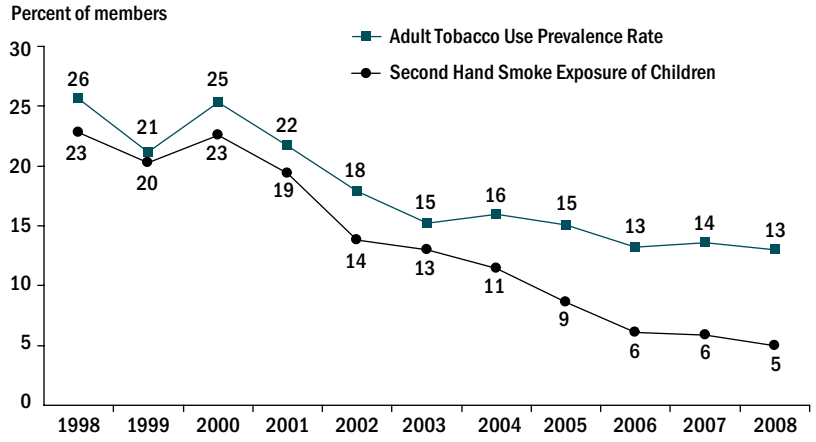
Measuring what is important. Optimizing care for chronic conditions can improve patient outcomes while also reducing costs. For example, HealthPartners found that diabetic patients whose risk factors for disease complications were not well controlled experienced $60,000 in average medical costs per year, as compared to $5,000 for those whose risk factors were controlled. However, the current practice of measuring individual care processes separately can obscure the need to address all of the risk factors affecting a patient's health outcomes.

In response, HealthPartners in 1996 began developing composite measures ("bundles") of optimal care to set a high bar that would encourage clinicians to meet all evidence-based care practices. Bundles currently address diabetes, coronary artery disease, depression, preventive care, and lifestyle. By 2006, more than one in five health plan members with diabetes, hypertension, and heart disease met all cardiovascular risk targets and over half met four of five targets, contributing to 4,000 fewer deaths from heart disease.

Exhibit 7. HealthPartners Strategic Objectives

Dimensions	Key Strategic Objectives	Success Indicator
People	Live the HealthPartners values	Employee well-being Diversity
Health	Be the best at improving health	Healthier patients and members *Health Goals 2010* performance
Experience	Deliver an experience that consumers want and deserve at an affordable cost	Increased patient, member, and employer satisfaction
Stewardship	Deliver improved value, growth, and financial results	Growth Improved margin Reduced cost trends Documented community benefit

Exhibit 8. HealthPartners Health Plan: Tobacco Use and Exposure Rates



Note: Adult Prevalence Rate represents member responses to the question, "During the past year, have you used tobacco products such as cigarettes, cigars, pipes, snuff, or chewing tobacco?" Second Hand Smoke Exposure represents member responses to the question, "During the past year, have any of your children been exposed to second-hand smoke at home or day care?"
Source: HealthPartners.

Among approximately 20,000 members with diabetes, for example, this improvement means 100 fewer heart attacks, 740 fewer eye complications, and 140 fewer amputations annually compared to 1995, according to the health plan's calculations.

Agreeing on best care practices and supporting improvement at the clinic level. HealthPartners participates in and financially supports Minnesota's Institute for Clinical Systems Improvement (ICSI), which brings together health plans and medical groups to develop evidence-based clinical guidelines and sponsors collaborative improvement activities (see Appendix A). For example, the plan has been able to reduce unnecessary imaging studies for lower back pain—saving an estimated $6.6 million in 2007—in part because guidelines based on American College of Radiology recommendations were adopted collaboratively through a process facilitated by ICSI. HealthPartners promoted communitywide adoption by sharing decision-support algorithms for medical groups to embed in their own EHRs and processes. Allowing medical groups to implement the guidelines internally, rather than being subject to onerous preauthorization requirements, helped overcome their resistance to change, according to George Isham, M.D., medical director and chief health officer.

Several clinics within the HealthPartners Medical Group and contracted medical groups are among a growing number statewide participating in another collaborative ICSI initiative called DIAMOND (Depression Improvement Across Minnesota: Offering a New Direction), which is applying an evidence-based model known as IMPACT to improve the identification and treatment of depression in primary care practices.[23] ICSI identified common practice redesign (Exhibit 9) and payment reform elements to implement the model in a systematic, staged fashion among medical groups that demonstrate a readiness for change. The medical groups have negotiated with health plans to receive a periodic fee to cover the cost of these enhanced services based on evidence that they will ultimately reduce costs while improving patient outcomes.

Early results of the DIAMOND Initiative are promising: Patients in the participating clinics are more regularly being assessed with the PHQ-9 and are achieving substantially higher rates of treatment response and symptom remission than are primary care patients with depression statewide.[24]

Other innovations to improve the quality and efficiency of care saved the HealthPartners Medical Group an estimated $74 million in 2007 and almost $100 million in 2008. For instance, an initiative to increase the use of generic pharmaceuticals involved

analyzing data to identify opportunities for intervention, systematizing generic drug conversions by embedding standing orders in the EHR, giving clinicians feedback on their prescribing patterns, and communicating progress.[25] As a result of these efforts, generic prescribing rose to 72 percent in 2007 from 45 percent in 2002. With an average difference in cost between branded and generic drugs of almost $150 per prescription, each percentage point increase in the rate of generic usage translates to $1 million in savings.

Aligning incentives with goals. Management incentives are linked to the organization's improvement goals. Within the HealthPartners Medical Group, primary care physician compensation is based 87 percent on productivity to assure timely access to care in an efficient manner, 3 percent on quality and service metrics, and 10 percent on participation in improvement activities. Changing from salary- to productivity-based pay (while also implementing advanced-access scheduling, described below) was associated with a 38 percent increase in primary care physician productivity and a 20 percent decrease in cost per relative value unit of work from 1998 to 2002.[26] Implementing the Care Model Process and other interventions was associated with a further 14 percent increase in physician productivity along with increased patient satisfaction between 2004 and 2005, and physician productivity has continued to increase since that time.[27]

HealthPartners first began using payment incentives in 1996 to stimulate improvement among its contracted providers. In 2007, the health plan paid more than $21 million in incentives (representing about 2.2 percent of total reimbursement) to contracted medical groups and hospitals for meeting quality and patient-experience targets and contractually negotiated goals such as the use of health information technologies (see Appendix C). Some medical groups may redistribute incentives to individual physicians while others use the performance payment to fund improvements in their quality infrastructure.

HealthPartners was the first health plan to refuse to pay hospitals (and to prohibit them from billing its members) for so-called "never events," which are rare medical errors such as surgery on a wrong body part that should never happen to a patient. The health plan adopted this policy in 2005 following passage of a Minnesota law requiring hospitals to disclose such events. Medicare has since adopted a similar policy.

About 150,000 health plan members are enrolled in value-based tiered networks that encourage them to select efficient providers by varying copayment and coinsurance levels based on more than 70 measures of the cost and quality of care provided. To promote treatment adherence among individuals with chronic illnesses, the health plan also offers a value-based drug plan with reduced copayment or coinsur-

Exhibit 9. The DIAMOND Initiative: Key Components of Depression Care

1. Standard and reliable use of a validated screening tool—the PHQ-9 patient health questionnaire—for assessment and ongoing management of depression.
2. Systematic patient follow-up tracking and monitoring (based on repeat PHQ-9 measurements and use of a patient registry).
3. Use of evidence-based guidelines and a stepped-care approach for treatment modification or intensification.
4. Relapse prevention plan for patients ready to move out of the care management program.
5. Addition of a care manager to staff to educate, coordinate, and troubleshoot services for patients with depression. (HealthPartners trained medical assistants to fill this role under the supervision of the consulting psychiatrist.)
6. Psychiatric consultation and caseload review.

Source: Institute for Clinical Systems Improvement, the DIAMOND Initiative, http://www.icsi.org/diamond_white_paper_/diamond_white_paper_28676.html.

ance levels for certain drug categories used to treat chronic conditions.

Making results transparent. HealthPartners measures comparative clinical indicators of performance for its network providers and for the health plan as a whole. It has reported these results to providers and the public for more than 10 years.[28] In addition, the HealthPartners Medical Group has joined more than 120 other physician group practices in the region in publicly reporting clinical performance as part of the Minnesota Community Measurement initiative, a nonprofit collaboration between the state medical association and participating medical groups, consumers, businesses, and health plans (see Appendix A). For 2007, HealthPartners Medical Group received three stars (the highest rating representing above-average performance) in nine of the 11 clinical categories reported by Minnesota Community Measurement.

EASY ACCESS TO APPROPRIATE CARE

HealthPartners offers centralized scheduling, urgent care clinics, and open-access health plan options that do not require a referral to see a specialist. Health plan members have access by phone to assistance in several forms including "nurse navigators" for questions about coverage, networks, and services; the Personalized Assistance Line, for questions related to behavioral health issues; the nurse-staffed CareLine, for after-hours advice on treatment options; and the BabyLine, staffed by trained ob-gyn nurses for questions related to pregnancy and postmaternity care.

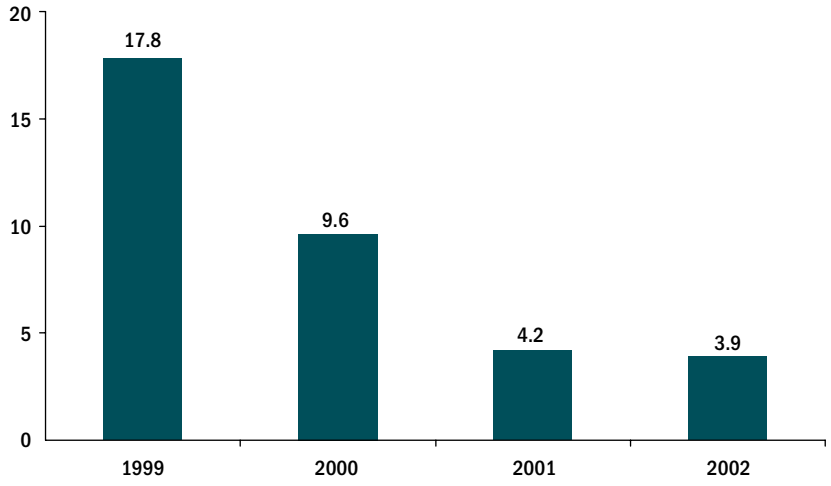
The organization is testing several innovative models of primary care delivery to improve access, preserve or improve quality, and expand service offerings. For example, convenience clinics are being developed as a response to so-called "minute clinics" in retail stores, focusing on delivering quality of care that is equal or superior to traditional primary care delivery, and on integration with traditional clinics. "Well@ Work" is a primary care program offered at the workplace that combines acute care services, health risk assessment, health promotion, and behavior modification. To help improve rates of breast cancer screening among underserved populations, two HealthPartners Medical Group clinics began offering same-day mammograms to women who were due or overdue for screening at the time of a clinic visit. Results were promising, and the innovation is being spread to other locations with on-site mammography service.

Reducing Appointment Waiting Time. In 2000, the HealthPartners Medical Group instituted advanced-access scheduling in 17 primary care clinics to promote the availability of standardized, same-day appointments with a patient's regular physician. Today, all primary care clinics offer same-day access and almost 30 percent of primary care visits are same-day appointments. Researchers who studied the change reported that the most important influences on successful implementation were strong leadership and accountability, both locally and centrally; a clear vision and well-defined plan of action (developed with the assistance of outside consultants); and training, teamwork, and support through collaborative learning sessions to help clinics overcome obstacles to change.[29] The researchers reported the following results:

- Overall, advanced-access scheduling led to a 76 percent reduction in average waiting time at the 17 clinics, from 17.8 days in 1999 to 4.2 days in 2001 (Exhibit 10). (Waiting time was measured to the third-next-available appointment to minimize variations due to canceled appointments.) Patient satisfaction rose during this time, from 36 percent to 55 percent of patients reporting being "very satisfied" with quality and service.

- Among patients with diabetes, heart failure, and/or depression, advanced access was accompanied by a 5 percent to 9 percent decrease in urgent-care visits, a higher proportion of physician visits being made to primary care physicians, and increased continuity of care with the same physician.[30] Better continu-

Exhibit 10. HealthPartners Medical Group: Effect of Advanced Access Scheduling on Appointment Waiting Time



Source: L. I. Solberg, M. C. Hroscikoski, J. M. Sperl-Hillen et al., "Key Issues in Transforming Health Care Organizations for Quality: The Case of Advanced Access," Joint Commission Journal on Quality and Safety, January 2004 30(1):15–24.

ity of care was associated with improved quality of care for diabetic patients.[31]

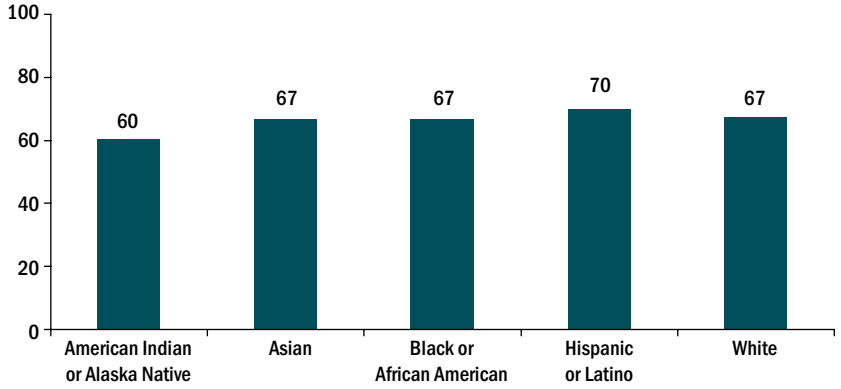
Improving Cultural Competency. HealthPartners is engaged in a multifaceted initiative to improve its ability to deliver equitable care in a linguistically and culturally competent manner for patients of varying racial and ethnic backgrounds.[32] At the care delivery level, the organization is seeking to instill equity as a principle to be achieved through a consistent care process across its facilities, while customizing services to meet individual needs. Programmatic components of the initiative include:

- Establishing a consistent process for asking patients to voluntarily provide demographic information, including race and country of origin (collected at the point of care) as well as language spoken and need for interpreter services (collected during appointment scheduling), to help guide and improve care delivery.
- Broadening the diversity of its workforce (among whom several languages are spoken) and providing training, resources, and tools such as professional interpreters, translated materials, and educational resources about immigrant populations to help bridge language and cultural barriers. (Minnesota is first in the nation in refugees as a percentage of immigrants, with the largest Hmong, Somali, and Oromo populations in the U.S.)
- Developing the "Language Assistance Plan" to systematize best practices for interpreter services. The plan includes a user's guide that describes how and when to access services, a provider manual that establishes quality and performance expectations for interpretation service providers, an annual survey to gauge staff satisfaction with different interpreting methods, and reimbursement information related to interpretation services.[33]
- Sponsoring leadership symposiums, community forums, and other forms of outreach to cultural groups in its communities to build trust, gain insight into health care access needs, and solicit advice on how to improve communication and care delivery.

Results to date include the near-elimination of ethnic/racial disparities in a composite measure of adult preventive care among Asian, Hispanic/Latino, and Black/African American patients as compared to

Exhibit 11. HealthPartners' Cultural Competency Initiative: Preventive Services Composite Measure*

Percentage of patients seen during the quarter who received all preventive screening appropriate to each patient's age and gender, third quarter 2007



*Composite includes cholesterol, colon cancer screening, mammography, Chlamydia screening, and pap smear.
Source: B. Averbeck and N. McClure, "Toward Equity, Addressing Disparities in Care and Experience." Presented at the American Medical Group Association Annual Conference, Orlando, Fla. March 6–8, 2008.

white patients (Native Americans continue to experience a lower rate), and the elimination of disparities between white and non-white patients in the provision of heart-attack and pneumonia care in the hospital (Exhibit 11).

RECOGNITION OF PERFORMANCE

In addition to the results of the specific interventions described above, HealthPartners has achieved notable results on selected externally reported performance indicators and has received recognition for its performance from several national benchmarking or award programs (Exhibit 12). In terms of efficiency, data from the *Dartmouth Atlas of Health Care*, which examined care at the end of life for Medicare patients with chronic illness, indicate that those who received the majority of their inpatient care at Regions Hospital had similar overall Medicare spending per person but fewer hospital days (68 percent) and physician visits (61 percent) compared to the U.S. average.[34]

The identification of areas of excellence does not mean that HealthPartners has achieved perfection, however. Like the other organizations in this case-study series, HealthPartners has room for continuing improvement in several areas of care. For example, Regions Hospital reported six patient falls resulting in serious disability during a one-year period from Oct. 2007 to Oct. 2008, according to the Minnesota Department of Health.[35] The organization's track record of improvement suggests that it will continue to innovate so as to achieve higher levels of performance. In this instance, the hospital has joined a collaboration sponsored by the Minnesota Hospital Association to support efforts to reduce patient falls.

INSIGHTS AND LESSONS LEARNED

Key factors driving HealthPartners' performance, according to its CEO, Mary Brainerd, and chief health officer, George Isham, M.D., are the organization's nonprofit, consumer-focused mission as well as the leadership and accountability engendered by a consumer-elected board. "We have a very clear line of sight to who our customer is. We're not confused at all about who we need to solve health care problems for: It's for the end consumer," Brainerd said.

Brainerd also said she sees "huge opportunities" for an integrated system like HealthPartners "to support our members and patients much more effectively, addressing their health needs not only when they're in the exam room in the traditional means, but [also] supporting them through programs at the work site, through linking care delivery and disease management and health improvement capabilities we have developed across the organization." Organizational

traits that promote integrated health care delivery at HealthPartners include a regional focus, scale, and scope integrating a broad range of services, the strategic use of electronic health records, and skills for measuring quality and improving care that have been honed over many years.

Although the EHR has been an important tool supporting change, reaping its potential has been an evolutionary process. "Not all the improvements that HealthPartners has realized are attributable to its EHR, and not all the improvements that the EHR may facilitate have yet been achieved," Isham said. The medical group found that first-generation EHR products had to be adapted to include more advanced functions such as disease registries and decision support to enable the full scope of quality improvement and changes in clinical practice. Because automating traditional ways of working will not enable breakthroughs in performance, HealthPartners follows a design principle that desired clinical workflow should drive the EHR workflow, and not vice versa.

Brainerd is quick to admit that the organization "has a huge distance to go" to realize its goals for transforming health care delivery. Motivating change

Exhibit 12. Selected Externally Reported Results and Recognition*

Inpatient Care Quality[36] (CMS Hospital Compare Jan.–Dec. 2007)	*Heart attack treatment* (8 measures): Regions Hospital ranked in the top decile of U.S. hospitals evaluated.
	Heart failure treatment (4 measures): Regions Hospital ranked in the top quartile of U.S. hospitals evaluated.
	Pneumonia treatment (7 measures): Regions Hospital ranked in the top quartile of U.S. hospitals evaluated.
	Overall patient rating of care (HCAHPS): Westfields Hospital ranked in the top decile of U.S. hospitals reporting.
Ambulatory Care Quality (NCQA Quality Compass 2008)	*Clinical quality* (33 measures): HealthPartners ranked in the top quartile of commercial health plans nationally or regionally on 23 measures, 13 of which were in the top decile.
	Patient experience (10 measures): HealthPartners ranked in the top quartile of commercial health plans nationally or regionally on two measures.
National Recognition and Ratings	*Verispan Top 100 Integrated Health Networks* (2005–2007).
	Leapfrog Group: Regions Hospital designated one of 13 "Highest Value Hospitals" for efficiency in treating heart disease and pneumonia (2008).
	National Committee for Quality Assurance: Health Plan Excellent Accreditation; Quality Plus Distinction in Care Management, Health Improvement, and Member Connections; Diabetes Physician Recognition Program (HealthPartners); Innovations in Multicultural Health Care Award.
	US News & World Report *Best Health Plans*: HealthPartners ranked among the top 25 Medicare plans in 2005 and among the top 50 commercial plans in 2006–2008.
	JD Power and Associates National Health Insurance Plan Study: Among commercial health plans evaluated nationally, HealthPartners ranked in the top decile in 2008 (104 plans) and the top quartile in 2009 (128 plans). In the Minnesota/Wisconsin region, HealthPartners ranked first among six plans evaluated in 2008 and second among eight plans in 2009.
	National Business Coalition on Health eValue8: HealthPartners HMO and/or PPO was the Benchmark Health Plan in six areas in 2007 and in seven areas in 2008.
	National Quality Forum: National Quality Healthcare Award (2007).
	American Medical Group Association: Acclaim Award (2006) to the HealthPartners Medical Group for its primary care clinic workflow standardization care model process.

*See the Series Overview, Findings, and Methods for analytic methodology and explanation of performance recognition. CMS = Centers for Medicare and Medicaid Services; HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems; NCQA = National Committee for Quality Assurance (Quality Compass 2008 represents the 2007 measurement year); HMO = health maintenance organization; PPO = preferred provider organization.

in the workforce requires an "absolute willingness to reject the status quo and take the risk of pointing out the flaws in the current system so that across the organization you have people who are willing to…let go of the traditional ways of doing things," Brainerd said. She notes that the workforce is often motivated by a "show-me rather than tell-me" approach: Engaging in a role-playing activity, or seeing a video of a patient relating her experience, can be more effective than a lecture or memo in helping staff to understand the human impact of poor quality and to internalize the goals for improvement.

> Ultimately, health care reform should seek not only to "defragment" health care delivery so that it is less chaotic, but also to develop the infrastructure and performance framework that health care organizations will need to achieve their potential for providing optimal care.
>
> *HealthPartners Chief Medical Officer George Isham, M.D.*

HealthPartners' experience suggests that a nonprofit health plan market oriented to physician group practice and supported by collaborative measurement and improvement organizations creates a community environment that helps each participant achieve its objectives more effectively. Isham noted that collaborating with other health plans and medical groups through the Institute for Clinical Systems Improvement develops common "know-how" and critical mass for making changes in clinical practice that physicians might otherwise resist or lack the ability to bring about on their own. Giving physicians a forum to develop clinical guidelines and improvement strategies that are recognized throughout the community enables HealthPartners to find common ground with those physicians more easily as they pursue common goals, said Michael Trangle, M.D., associate medical director for the behavioral health division.

By setting ambitious objectives across its member population—whether they receive care in owned or contracted settings—and engaging providers in a common measurement and reporting scheme, HealthPartners encourages physicians to improve by appealing to their professional reputation. "I think people take pride in the fact that they're actively, collectively improving diabetes care in their medical group here in Minnesota," said Isham. These efforts are supported by common metrics for performance incentives that health plans and employers have agreed upon through their participation in the Minnesota Community Measurement public reporting initiative and the Minnesota Bridges to Excellence pay-for-performance program (see Appendix A).

This market alignment increases the power of incentives while also reducing the burden of measurement. "The reason that it works in Minnesota is that people are committed to that framework and they get something out of it. They get decreased hassle in terms of different measurement frameworks, they get more alignment, they get more power for their own incentive programs because they're pooled with everybody else's," Isham said. Despite these strides, the *Minneapolis-St. Paul Business Journal* recently reported that some Minnesota doctors still complain about the administrative burden created by subtle differences in eligibility for incentives.[37]

While participating in this collaborative environment, HealthPartners has continued to innovate in developing approaches that are important to achieving a higher-performing health system. For example, the organization is increasingly focused on improving health, not just health care, through strategies such as measurement and intervention on lifestyle risk factors. It is also supporting practice redesign both in its own clinics and in contracted medical groups so that physicians can build internal capacity for managing chronic diseases more effectively. These efforts hold the promise of providing an evolutionary path toward broader implementation of the primary care "medical home" model.

HealthPartners' shift to an open health plan network (in which individuals have a choice among contracted medical groups and HealthPartners' own clin-

ics) has had both positive and negative consequences, according to Brainerd and other system leaders. The change was necessary for market survival and has motivated HealthPartners to innovate and improve as it competes for members and patients in a marketplace that values choice at both the health plan and physician group level. "We want to be the one they choose," said Beth Averbeck, M.D., associate medical director for quality and primary care. A mixed-model network also allows HealthPartners to involve physicians in its internal medical group in testing innovations before rolling them out to contracted groups.

On the other hand, market adaptation has shifted the organization's orientation away from its roots in prepaid practice and toward the fee-for-service reimbursement model, which doesn't reward care coordination or cost-efficient practice. The organization has adapted to this market dynamic by leading the development and use of performance information and incentives to help overcome the limitations of fee-for-service payment. In the future, Brainerd would like to see a further shift toward episode-based payment to promote greater accountability for the total care of the patient. Ultimately, health care reform should seek not only to "defragment" health care delivery so that it is less chaotic, Isham said, but also to develop the infrastructure and performance framework that health care organizations will need to achieve their potential for providing optimal care.

For a complete list of case studies in this series, along with an introduction and description of methods, see *Organizing for Higher Performance: Case Studies of Organized Health Care Delivery Systems—Series Overview, Findings, and Methods*, is available online at www.commonwealthfund.org.

NOTES

[1] T. Shih, K. Davis, S. Schoenbaum et al., *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund Commission on a High Performance Health System, Aug. 2008).

[2] Information on HealthPartners was synthesized from telephone interviews and e-mail correspondence with the individuals named in the Acknowledgments; from a presentation by George Isham, M.D., to the Commission on a High Performance Health Care System, Minneapolis, July 2007; a presentation by Donna Zimmerman to the Partnership for Quality Care Summit, Washington, D.C., March 2008; and from other presentations and published literature (cited below), information on the organization's Web site, and HealthPartners' application for the National Quality Forum's National Quality Healthcare Award.

[3] A summary of findings from all case studies in the series can be found in D. McCarthy and K. Mueller, *Organizing for Higher Performance: Case Studies of Organized Delivery Systems—Series Overview, Findings, and Methods* (New York: The Commonwealth Fund, 2009).

[4] S. Silow-Carroll and T. Alteras, *Value-Driven Health Care Purchasing: Case Study of Minnesota's Smart Buy Alliance* (New York: The Commonwealth Fund, August 2007).

[5] According to the Minnesota Department of Health, HealthPartners' 2007 market share was 25 percent of the fully insured private market by premiums and 40 percent of HMO enrollment in the state (Minnesota Health Care Markets Chartbook, http://www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html).

[6] R. L. Reece, "EMRs Help Transform Processes of Care for HealthPartners' Physicians: Interview with Kevin Palattao," *Practice Options*, July 2004:8–11.

[7] K. J. Palattao, "Connecting with Patients: HealthPartners' eStrategy Is Good Business," *Group Practice Journal*, Oct. 2005 54(9):9–16.

[8] The plan reports readmission rates representing the percentage of patients who were readmitted with fluid and electrolyte imbalance, pneumonia or cardiac-output disorders diagnosed within 90 days, 60 days, and 30 days of an initial heart failure hospital discharge over a two-year period. D. Wehrle and S. Bussey, *HealthPartners 2008 Clinical Indicators Report* (Bloomington, Minn.: HealthPartners, 2008).

[9] N. D. Beaulieu, D. M. Cutler, K. E. Ho et al., *The Business Case for Diabetes Disease Management at Two Managed Care Organizations: A Case Study of HealthPartners and Independent Health Association* (New York: The Commonwealth Fund, April 2003). The authors estimated that, for a patient enrolled in HealthPartners' diabetes disease management program for 10 years, the savings in avoided medical costs would exceed the operating cost of the program by $75 per patient. The economic value of improved quality of life assumed a 1 percent improvement in hemoglobin A1c level. The authors concluded that "the magnitude of the difference between costs and patient benefits is so great that we believe, at the social level, the outcomes of these comprehensive programs will always be worth the investment needed."

[10] According to data from the National Committee for Quality Assurance's *Quality Compass 2008*, HealthPartners ranked in the top 10 percent of commercial health plans on a measure of antidepressant medication continuation (percentage continuing on an antidepressant for at least six months), achieving a rate of 57.8 percent in 2007 as compared to a national average of 46.1 percent.

[11] The plan is investigating the degree to which the reduction in medication costs reflects increased substitution of generic for brand medications.

[12] HealthPartners, The "Your Health Potential" Health Assessment. For an example of one predictive algorithm, see: T. L. Pearson, N. P. Pronk, A. W. Tan et al., "Identifying Individuals at Risk for the Development of Type 2 Diabetes Mellitus," *American Journal of Managed Care*, 2003 9(1):57–66.

[13] N. Pronk and M. Thygeson, "From Managing Disease to Managing Health," *Group Practice Journal*, Oct. 2006: 9–12; N. M. Thygeson, J. Gallagher, K. Cross et al., "Employee Health at BAE Systems: An Employer-Health Plan Partnership Approach," *ACSM's Worksite Health Handbook, Second Edition. A Guide to Building Healthy and Productive Companies*, N. P. Pronk, ed. (Champaign, Ill.: Human Kinetics, 2009; Chapter 36).

[14] E. H. Wagner, B. T. Austin, and M. Von Korff, "Organizing Care for Patients with Chronic Illness," *Milbank Quarterly*, 1996 74(4):511–44.

[15] Information on the Care Model Process was obtained in part from M. McGrail and B. Waterman, "HealthPartners Medical Group: Care Model Process," *Group Practice Journal*, Nov./Dec. 2006 55(10):9–20; Anonymous, "Pursuing Perfection: Report from HealthPartners on Prepared Practice Teams," *Improvement Stories* (Boston: Institute for Healthcare Improvement, undated); B. Averbeck and B. Waterman, "Embedding Reliability in Ambulatory Care: The Care Model Process," presented at the Institute for Clinical Systems Improvement's Colloquium on Redesign for Results Quantum Leaps in Healthcare, St. Louis Park, Minn., May 2007, http://www.icsi.org/colloquium_-_2007/averback.html.

[16] Researchers who studied the redesign at an early stage found a 24 percent improvement in chronic care model implementation overall from 2002 to 2004 (changes were variable across sites) along with concurrent improvements in quality of care for diabetes, heart disease, and depression. Changes in some care model components correlated with improvement in diabetes control. L. I. Solberg, A. L. Crain, J. M. Sperl-Hillen et al., "Care Quality and Implementation of the Chronic Care Model: A Quantitative Study," *Annals of Family Medicine*, 2006 4(4):310–16.

[17] A review of factors that contributed to improved diabetes care in the HealthPartners Medical Group from 1995 to 2005 identified "drug intensification, leadership commitment to diabetes improvement, greater continuity of primary care, participation in local and national diabetes care improvement initiatives, and allocation of multidisciplinary resources at the clinic level to improve diabetes care." J. M. Sperl-Hillen and P. J. O'Connor, "Factors Driving Diabetes Care Improvement in a Large Medical Group: Ten Years of Progress," *American Journal of Managed Care*, 2005 11:S177– S185.

[18] K. Kroenke, R. L. Spitzer, and J. B. Williams, "The PHQ-9: Validity of a Brief Depression Severity Measure," *Journal of General Internal Medicine*, 2001 16(9):606–13.

[19] M. C. Hroscikoski, L. I. Solberg, J. M. Sperl-Hillen et al., "Challenges of Change: A Qualitative Study of Chronic Care Model Implementation," *Annals of Family Medicine*, 2006 4(4):317–26.

[20] Information in this section was based in part on a presentation by George Isham, M.D., to the Commission on a High Performance Health Care System, Minneapolis, July 2007.

[21] D. Wehrle and S. Bussey, *HealthPartners 2008 Clinical Indicators Report Technical Supplement* (Bloomington, Minn.: HealthPartners, 2008).

[22] ClearWay Minnesota, Blue Cross and Blue Shield of Minnesota, and Minnesota Department of Health, *Creating a Healthier Minnesota: Progress in Reducing Tobacco Use* (Minneapolis: Minnesota Center for Health Statistics, Sept. 2008).

[23] Institute for Clinical Systems Improvement, *Groundbreaking Approach for Improving Depression Care Introduced at 10 Minnesota Clinics* (Minneapolis: ICSI, May 2008). Information about the IMPACT model of depression care, and the evidence base supporting it, can be found at http://impact-uw.org/.

[24] Personal communication with Michael Trangle, M.D., associate medical director, HealthPartners Behavioral Health Division, Jan. 2009. Comparable measures of assessment, treatment response, and remission are being collected by the Minnesota Community Measurement Initiative.

[25] R. A. Williams and J. Flaaten, "Maximizing Pharmaceutical Affordability: Systematically Improving Generic Utilization," presented at the Medical Group Association Annual Conference, Orlando, March 7, 2008.

[26] S. Lewandowski, P. J. O'Connor, L. I. Solberg et al., "Increasing Primary Care Physician Productivity: A Case Study," *American Journal of Managed Care*, 2006 12:573–76. Productivity-based pay was instituted at about the same time as primary care clinics adopted advanced-access scheduling.

[27] Averbeck and Waterman, "Embedding Reliability in Ambulatory Care: The Care Model Process."

[28] R. Bohmer and N. D. Beaulieu, *HealthPartners* (Cambridge, Mass.: Harvard Business School, Nov. 1999).

[29] L. I. Solberg, M. C. Hroscikoski, J. M. Sperl-Hillen et al., "Key Issues in Transforming Health Care Organizations for Quality: The Case of Advanced Access," *Joint Commission Journal on Quality and Safety*, Jan. 2004 30(1):15–24. At the time as it instituted advanced-access scheduling, the medical group also introduced a call center for booking patient appointments and converted physician compensation from salary to a system based mainly on productivity. The researchers reported that these changes both facilitated and challenged the implementation of advanced access across the system.

[30] L. I. Solberg, M. V. Maciosek, J. M. Sperl-Hillen et al., "Does Improved Access to Care Affect Utilization and Costs for Patients with Chronic Conditions?" *American Journal of Managed Care*, 2004 10(10):717–22.

[31] J. M. Sperl-Hillen, L. I. Solberg, M. C. Hroscikoski et al. , "The Effect of Advanced Access Implementation on Quality of Diabetes Care," *Preventing Chronic Disease*, Jan. 2008 5(1): A16. The study used multilevel logistic regression to predict performance on composite measures of performance controlling for patient age, sex, and coronary artery disease status.

[32] B. Averbeck and N. McClure, "Toward Equity: Addressing Disparities in Care and Experience," presented at the American Medical Group Association 2008 National Conference, Orlando, Fla., March 2008. HealthPartners, *Strategies to Identify and Reduce Health Disparities* (Bloomington, Minn.: HealthPartners, 2007), http://www.healthpartners.com/files/40901.pdf.

[33] National Health Plan Collaborative, "HealthPartners: Formalizing Organizational Best Practices for Language Services Through the Development of a Language Assistance Plan" (Princeton, N.J.: Robert Wood Johnson Foundation, 2008).

[34] Dartmouth Atlas Project, http://www.dartmouthatlas.org. The analysis focused on Medicare patients with one of nine chronic conditions who died between 2001 and 2005, controlling for differences in patients' age, sex, race, and primary chronic diagnosis.

[35] Minnesota Department of Health, *Adverse Health Events in Minnesota: Fifth Annual Public Report* (St. Paul: Minnesota Department of Health, Jan. 2009).

[36] Rankings for CMS Hospital Compare clinical topics (heart attack, heart failure, and pneumonia treatment and surgical care improvement) included hospitals that reported on all measures and recorded at least 30 patients in each topic. Only results in the top quartile are noted. One HealthPartners hospital (Regions Hospital) was evaluated on clinical topics and two (Regions and Westfields Hospitals) on HCAHPS results. The HCAHPS overall rating of care means a patient rating of 9 or 10 on a 10-point scale. The analysis did not include Hudson Hospital since it was not part of the organization during the time periods studied.

[37] N. R. Orrick, "Doctors' Group Knocks Insurers' Performance Plans," *Minneapolis/St. Paul Business Journal*, Nov. 19, 2007.

Appendix A. Collaborative Organizations in Minnesota

Several Minnesota organizations are active in promoting improvements in health care delivery through information-sharing and collaborative learning. Among them are:

Minnesota Community Measurement (http://www.mnhealthcare.org), a nonprofit collaboration between the Minnesota Medical Association and participating medical groups, consumers, businesses, and health plans in Minnesota and surrounding states. The group's objectives are to improve care and support quality initiatives, reduce reporting-related expenses, and communicate fair, usable, and reliable findings. It publishes information on the quality of care provided by more than 120 physician practices. Measures have been adapted primarily from the Healthcare Effectiveness Data and Information Set (HEDIS) to align with clinical guidelines established by the Institute for Clinical Systems Improvement. The group also has developed composite measures of optimal care for diabetes and coronary artery disease.

The ***Institute for Clinical Systems Improvement*** **(ICSI)** (http://www.icsi.org), which promotes evidence-based practice and the redesign of the health care delivery system through the development and dissemination of consensus-driven clinical guidelines and payment models. ICSI also facilitates stakeholders' collaboration in the development of patient- and value-centered models of care for women's health, preventive care, and various health conditions. ICSI supports providers in transforming their practices and implementing quality improvement activities through collaborative learning. ICSI's membership includes more than 50 medical groups (physician group practices) located in Minnesota and adjacent states, and six health plans that sponsor the organization financially.

Bridges to Excellence **(BTE)** (http://bridgestoexcellence.org), a national collaboration that recognizes and rewards health care providers who reengineer their practices to deliver care consistent with the Institute of Medicine's aims for the health system. The program is active in 20 states; Minnesota's effort is led by the Buyer's Health Care Action Group (http://www.bhcag.com), a coalition of private and public employers, in collaboration with health plans, the Minnesota Medical Society, providers, ICSI, and Minnesota Community Measurement. The BTE pay-for-performance model focuses on reducing defects, misuse, and waste in health care. Jim Reimann, an independent consultant, kindly shared perspective on the Minnesota market environment. Incentives are based upon publicly reported data consistent with the efforts of the National Committee for Quality Assurance (http://www.ncqa.org) and Minnesota Community Measurement.

Appendix B: HealthPartners Health Goals 2010

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Health Goals 2010 High-Level Summary for September 2008

	Health Goal	Sept 2008 Results	Infra-structure Improvement	Relative Position to Competitors
1	Customers receive amazingly easy to use care, coverage, and service (E)			
2	Customers receive maximum quality and affordability in health care (E/H)			
3	Patients and members receive equitable care and service (H)			
4	Customers feel they are treated as individuals (E)			
5	Patients and members have the information they need and understand to be effective decision-makers (E/H)			
6	Customers are incented and supported for self care and healthy behaviors			
7	Customers experience perfect transitions among clinicians, patients, family, payers, and community support (E/H)			
8	Customers receive evidence-based care, creating an efficient path to recovery (H)			
9	Members and patients will have help to be healthy (H)			
10	Members and patients will have help with health/life transitions (H)			
11	Members and patients will live well with acute and chronic illness and disease (H)			
	Diabetes Care			
	Vascular Disease			
	Cancer Care			
	Bone & Joint Disease Care			
	Depression Care			
	Asthma Care			
12	Members and patients will be safe (H)			

Health Goal Progress Key:

Goal achieved / infrastructure in place with full spread / position relative to competition strong	
Positive performance trend / infrastructure in place / position relative to competition good	
Stable performance / infrastructure in design or early implementation / position relative to competition is neutral	
Measurement development in progress or unstable performance / early infrastructure design in process / position relative to competition is weak	
Performance measurement not yet established / infrastructure in the planning stage / not applicable	

Partners in Excellence – 2009 Primary Care Targets

Primary Care Groups: > 1,500		Excellent	Superior
MNCM Optimal Diabetes Care DDS		Pending MNCM/ICSI decision on HbA1C level	Pending MNCM/ICSI decision on HbA1C level
MNCM Optimal Vascular Disease Care DDS		**55%**	**60%**
Optimal Depression Care		**45%**	**50%**
Evidence-based Cervical Cancer Screening		**45%**	**55%**
Alcohol Assessment		**90%**	**95%**
Preventive Services – Adult		**93%**	**98%**
Generic Drug Use		**75%**	**80%**
Low back Pain Composite Measure		**15%**	**25%**
Patient Satisfaction	***"Informed about your care"***	**Top Band**	
	"Talked about pros & cons for any choices for your treatment or health care"	**Top Band**	
HP Innovations in Health Care Award HP Innovations in Shared Decision Making (tech specs)			

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Partners in Excellence – 2009 Primary Care Targets

Primary Care Groups between 100 - 1,500	Excellent	Superior
MNCM Optimal Diabetes Care DDS	Pending MNCM/ICSI decision on HbA1C level	Pending MNCM/ICSI decision on HbA1C level
MNCM Optimal Vascular Care DDS	**55%**	**60%**
Evidence-based Cervical Cancer Screening	**45%**	**55%**
MNCM Breast Cancer Screening	**80%**	**85%**
Generic Drug Use	**75%**	**80%**
HP Innovations in Health Care Award HP Innovations in Shared Decision Making (tech specs)		

Partners in Excellence – 2009 Pediatric Targets

Pediatrics		Excellent	Superior
Part 1: BMI Assessment – Pediatric Part 2: Preventive Services - Pediatric		**80 %** **75 %**	**85 %** **80 %**
MNCM Pediatric Immunization Combo 3		**90 %**	**95 %**
Patient Satisfaction:	***"Informed about your care"***	**Top Performer**	
	"Talked about pros & cons for any choices for your treatment or health care"	**Top Performer**	
Generic Drug Use		**70 %**	**75%**
HP Innovations in Health Care Award HP Innovations in Shared Decision Making (tech specs)			

Partners in Excellence – 2009 Specialty Targets

Specialty	2009 Measure		Excellent	Superior
Cardiology	CMS Heart Failure Re-admissions		**30 day < or = 10%**	**30 day < or = 5%**
	Generic Drug Use		**75%**	**80%**
	Patient Satisfaction	*"Informed about your care"*	**75%**	**80%**
		"Talked about pros & cons for any choices for your treatment or health care"	**Top Band**	
Ortho	DVT/PE Infection Measure		**0.5 index or lower** (Index rate*)	
	Patient Satisfaction	*"Informed about your care"*	**80%**	**85%**
		"Talked about pros & cons for any choices for your treatment or health care"	**Top Band**	
OB/GYN	Generic Drug Use		**75%**	**80%**
	DVT/PE Infection Measure		**0.5 index or lower** (Index rate*)	
	Alcohol Assessment		**90%**	**95%**
	Patient Satisfaction	*"Informed about your care"*	**87%**	**92%**
		"Talked about pros & cons for any choices for your treatment or health care"	**Top Band**	

Index rate: Rate based on total network average. *"Provider group had ≤0.5 (1/2) lower complications compared to total network."*

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Partners in Excellence – 2009 Specialty Targets

Specialty	2009 Measure		Excellent	Superior
ENT	Generic Drug Use		**75%**	**80%**
	Patient Satisfaction	*"Informed about your care"*	**71%**	**76%**
		"Talked about pros & cons for any choices for your treatment or health care"	**Top Band**	
Behavioral Health	Generic Drug Use		**70%**	**75%**
	Optimal Depression Care		**55%**	**60%**
PT	Functional Assessment/Oswestry Compliance	Initial	**75 %**	See Combined Measure
		Longitudinal	**35 %**	See Combined Measure
		Combined	**N/A**	**75 % Initial and 35 % Longitudinal**

All	HP Innovations in Health Care Award HP Innovations in Shared Decision Making (tech spec)	

Index rate: Rate based on total network average. *"Provider group had ≤0.5 (1/2) lower complications compared to total network."*

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The aim of Commonwealth Fund–sponsored case studies of this type is to identify institutions that have achieved results indicating high performance in a particular area of interest, have undertaken innovations designed to reach higher performance, or exemplify attributes that can foster high performance. The studies are intended to enable other institutions to draw lessons from the studied institutions' experience that will be helpful in their own efforts to become high performers. It is important to note, however, that even the best-performing organizations may fall short in some areas; doing well in one dimension of quality does not necessarily mean that the same level of quality will be achieved in other dimensions. Similarly, performance may vary from one year to the next. Thus, it is critical to adopt systematic approaches for improving quality and preventing harm to patients and staff.